DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/14/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G074	A. BUILDING _____ B. WING _____	04/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	4012 LEE STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS This recertification survey was conducted from April 23 through April 25, 2008. The survey was initiated using the fundamental survey process. A random sample of two clients was selected from a residential population of three males with various degrees of disabilities. The findings of this survey were based on observations at the residence and day program, staff interviews at both the group home and day programs, review of clinical and administrative records to include the facility's unusual incident reports and policies.	W 000		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that each client, parent, or legally authorized party is informed of the client's medical conditions, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment for one of two clients in the sample. (Client #1) The finding includes: The facility failed to ensure Client #1 was informed of the risks and benefits of sedative	W 124	W124 MTS has developed standard consent forms specific to the issue of consent for sedation situations and for psychotropic drug regimens as well as one for medical procedures where informed consent is required. The QMRPs and nursing have been trained on their use and are using them for all such situations at this time. All future sedation situations will be implemented only after informed consent has been obtained from the guardian of Client #1 and the guardian or primary decision-making support person for each person supported who cannot provide informed consent themselves...5-30-08.	

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DEPARTMENT OF HEALTH
HEALTH REGULATION
ADMINISTRATION
2008 MAY 27 A 10:33

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Evette Moore | TITLE: Executive Director | (X6) DATE: 5/23/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 124	Continued From page 1 medication prior to administering it. Review of the medication administration records revealed that Client #1 received ativan 2 mg on December 4, 2007, prior to a audiology appointment. The record however, failed to have evidence that the client's guardian was made aware and gave consent for Client #1 to receive the medication prior to its administration. In an interview with the Qualified Mental Retardation Professional (QMRP) on April 25, 2008, at 10:00 AM she acknowledged that the Human rights committee was informed of the recommendation but the guardian was not made aware to give informed consent.	W 124		
W 126	483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities. This STANDARD is not met as evidenced by: Based on observation, staff interview and record verification, the facility failed to demonstrate that clients were granted their rights to manage their financial affairs and/or taught to do so to the extent of their capabilities for one of two clients in the sample. (Client #2) The finding includes: Interview with the Qualified Mental Retardation Professional on April 23, 2007 at approximately 3:30 PM, revealed that Client #2 was admitted on February 4, 2008. The QMRP further indicated that the client had an Individual Support Plan	W 126	*W126* Client #2 had his money management objective added to his program implementation plan in May...5-20-08. The QMRP had developed the objective but had not stated it pending staff training. The QMRP will insure that all objectives adopted by the IDT for each individual supported are implemented in the time frame prescribed and the Executive Director will audit compliance in her monthly meetings with each QMRP...5-30-08.	

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W 126	Continued From page 2 meeting on February 27, 2008. Observations and interview with the day program staff on April 24, 2008 at approximately 10:30 AM revealed that Client #2 participated in folding pizza boxes. The bilingual teacher at the client's day program indicated that after the client initial 30 day meeting, the client could potentially earn a stipend based on his work production. Review of the Client #2's clinical record revealed a Comprehensive Functional Assessment dated February 2007. the assessment revealed that the client could not identify coins or make coin combinations. Review of the client's Individual Program Plan (IPP) dated February 27, 2008 revealed no evidence that the facility had developed a program objective based on the money management needs identified in the client's comprehensive functional assessment.	W 126		
W 140	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of two of the two clients in the sample. (Clients #1 and #2) The finding includes: In an attempt to review the financial records for Clients #1 and #2 on April 24, 2008 there were no	W 140	W140 The client financial records mentioned are kept at the main office and have been faxed to HRA. The QMRP will insure in the future that the records are produced during the survey process as per normal practice and the Executive Director has spoken to the accounting staff member responsible for the maintenance and updating of these records about insuring the same. Such records will in the future be sent to the home on day one of any survey to insure they can be reviewed by the surveyor...5-30-08.	

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W 140	Continued From page 3 bank statements available. Interview with the Qualified Mental Retardation Professional (QMRP) on April 25, 2008 indicated that the bank statements were located in the main office and would be brought to the facility for review. By the end of the survey, the bank statement were not made available for review. It should be noted that the QMRP indicated that only Client #1 received a monthly Social Security Income (SSI). There was no other means available for Surveyors to assess the expenditures and management of client's funds.	W 140		
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview, review of unusual incidents, and review of medical records, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Section 3519.10) for three of the three clients in the sample. (Clients #1, #2, and #3) The findings include: 1. Review of the incident reports on April 23, 2008, at 4:30 PM revealed an incident that occurred on July 19, 2007 that documented Clients #1 and #3 were on a community outing	W 153	W153 MTS' management team which includes the President, Executive Director, QA/Special Projects Corporate Consultant, IMC/Corporate Consultant and Director of Nursing discussed this issue at length in the May 21st monthly team meeting and using this survey as evidence of the issue. Improvement in terms of timely notifications has been noted overall but some problems persist as outlined by the IMC. To insure that the IMC is immediately notified when incidents occur so that she can in turn insure timely notifications of other relevant parties including HRA, MTS' incident management procedure will be modified. The QMRP of Lee and each home will be made responsible for insuring that the IMC is notified immediately when incidents occur as opposed to delegating this responsibility to line staff as in the past. The RN will be responsible for notifying the PCP when issues involve physical health. Modifications in the existing guidelines, notification and training of the relevant staff and implementation of the new process will be completed by...6-10-08.	

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W 153	Continued From page 4 where a by-stander reported that staff was observed hitting the clients in the head and pulling on their clothing. The incident was reported to the administration on July 20, 2007; however, the incident was not reported to the state agency until August 4, 2007, 16 day later. 2. Review of the incident reports on April 23, 2008, at 4:30 PM revealed an incident that occurred on March 12, 2008 that documented Client #2 was on discovered missing from the facility. The incident was not reported to the state agency until March 15, 2008, three day later. 3. Review of the facility's incident reports on April 23, 2008 at approximately 4:00 PM revealed that on July 13, 2007 Client #1 was taken to the emergency room due to an enlarged scrotum. He received a sonogram at the ER and was diagnosed with epididymitis. The client was treated and discharged. On July 19, 2007 the client was evaluated by his primary care physician (PCP) noted the following: "contusion testicles and penis, supra-pubic, what caused the trauma? Why was I not notified? where is ER sheet?" The PCP ordered that the client see the Urologist. In an interview with the Qualified Mental Retardation Professional on April 25, 2008 at approximately 9:30 AM, she indicated that although the nurse indicated that she notified the physician, it was determined that the PCP's answering service was full and she could not leave a message. There was no evidence that the contusion to the clients scrotum was reported to the state agency and the administrator as required by their policies and District of Columbia regulations.	W 153	The RN in question for issue #3 has been re trained by the Director of Health to insure that she understands that she must continue to use options to contact the PCP until reached when medical concerns must be communicated. The nurse in question admits not going beyond the initial phone call to the PCP when she found the message box to be full. Other methods for reaching the PCP have been communicated and disseminated although this is an isolated incident and not an ongoing problem...5-30-08.	

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W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse and injuries of unknown origin were thoroughly investigated, for one of the three clients (Client #1) that resided in the facility. The finding includes: Review of the facility's incident reports on April 23, 2008 at approximately 4:00 PM revealed that on July 13, 2007 Client #1 was taken to the emergency room due to an enlarged scrotum. He received a sonogram at the ER and was diagnosed with epididymitis. The client was treated and discharged. On July 19, 2007 the client was evaluated by his primary care physician (PCP) noted the following: "contusion testicles and penis, supra-pubic, what caused the trauma? Why was I not notified? where is ER sheet?" The PCP ordered that the client see the Urologist. In an interview with the Qualified Mental Retardation Professional on April 25, 2008 at approximately 9:30 AM, she indicated that although the nurse indicated that she notified the physician, it was determined that the PCP's answering service was full and she could not leave a message. There was no evidence that the contusion to the clients scrotum was investigated.	W 154		
W 159	483.430(a) QUALIFIED MENTAL	W 159		

MTS
4201 Connecticut Avenue. NW, Suite #405, Washington DC 20008

FAX Cover Sheet

Fax No:202-442-9430

Date:5/23/08

To: Patricia VanBuren

No of pages (including cover sheet)

Message: 80

From: Evette Moore **Phone:202-244-4500**

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W 159	Continued From page 6 RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen. The findings include: Review of Client #1's record on April 25, 2008 at approximatekly 9:15 AM revealed that the client had a self medication program to "Get his water to take medication with 80% verbal assistance from staff." Review of the QMRP notes on April 25, 2008 at 9:30 AM failed to have evidence that the program was being monitored. In an interview with the QMRP on the same day at approximately 10:45 AM, she acknowledged that she had not been monitoring the clients progress in the aforementioned program.	W 159	W159 The Executive Director has reinforced with the QMRP that she must review progress on <u>all objectives</u> formally adopted by the IDT for each person supported including self medication objectives run by nursing. The QMRP began reviewing the self medication objective...5-20-08. Although this is not a concern elsewhere, the Executive Director reminded all QMRPs of this requirement in her May meeting with the Management team...5-20-08. In addition, the Executive Director will audit program implementation and review in her monthly meetings with each QMRP. QMRP duties checklists reflect this consideration...5-30-08.	
W 227	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that an	W 227	W227 The self medication process that was being done informally for Client #2 has been made a formal program objective that is now being run...5-20-08. See also W159 above.	

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W 227	Continued From page 7 objective was developed to address self medication training program need as identified by the interdisciplinary team (IDT) in the comprehensive assessment for one of the two clients in the sample. (Client #2) The finding includes: On April 24, 2008 at 7:21 PM, Client #2 was observed being administered his medications. The Licensed Practical Nurse (LPN) prepared the client's medications, the client poured a cup of water and the nurse handed the client the cup of medication and he consumed the medication with verbal prompts. Interview with the LPN indicated that the client did not have a self medication program. Review of the self medication assessment dated February 26, 2008 on April 25, 2008 at 10:00 AM indicated that the client would benefit from a modified version of a self medication program. Interview with the Qualified Mental Retardation Professional (QMRP) and Registered Nurse indicated that the program objective had not been developed. Review of the Individual Program Plan (IPP) dated February 27, 2008 revealed no program goal or objective for the client to receive training in self medication.	W 227		
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of	W 242	W242 Client #2 is newly admitted to the program (March 2008). A tooth brushing objective was added to his formal program plan in May...5-20-08. In addition nursing will insure that staff is trained to support Client #2 on a daily, routine basis when he brushes including; providing touch up and/or direct brushing support if needed to insure his teeth are thoroughly brushed...6-10-08.	

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W 242	Continued From page 8 acquiring them. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients' individual program plans (IPP) included training in personal skills in both formal and informal setting for one of the two clients in the sample. (Client #2) The finding includes: During the entrance conference with the Qualified Mental Retardation Professional (QMRP) on April 23, 2008 at approximately 3:30 PM revealed that Client #2 was admitted into the facility on February 4, 2008. On April 23, 2008, Client #2 was observed with brown stains on his teeth. Review of the client's medical record revealed a dental consultation dated March 18, 2008. The findings include moderate and heavy calculus deposit on all teeth quadrants. According to the comprehensive functional assessment dated February 2008 indicated that the client required assistance to thoroughly brush his teeth. Review of the client's IPP dated February 27, 2007 on April 24, 2008 at 3:00 PM failed to identified a toothbrushing program.	W 242		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the	W 249	W249 The library objective for Client #2 will be implemented by...6-15-08. Client #2 is a new admittance who came without all proper identification and as such, could not obtain a library card. The issue has been addressed at this point and his card will be obtained by...6-1-08.	

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W 249	Continued From page 9 objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that as soon as the interdisciplinary team formulated client's individual program plan, each client received continuous active treatment services, in sufficient number and frequency to support the achievement of the objectives identified in the Individual Program Plan (IPP), for one of the two clients included in the sample. (Client #2) The finding includes: The facility failed to implement Client #2's IPP as evidenced below: Interview with the Qualified Mental Retardation Professional (QMRP) and record review on April 23, 2008 revealed that Client #2 was admitted to the facility on February 4, 2008. Further interview revealed that the client had an Individual Habilitation Plan (IHP) meeting dated February 27, 2008. The interview with the QMRP revealed that the client's Individual Program Plan (IPP) to visit the library and select reading material had not been implemented. The surveyor askedd the QMRP about the implementation of Client #2's program. The QMRP's response was that the program would be implemented soon. At the time of the survey the facility failed to ensure the program to achieve the client's objective to visit the library had not been implemented.	W 249		

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W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs and sedative medications, were conducted with written informed consent of the client, parents (if the client is a minor) or legal guardian for one of the two clients in the sample (Client #1) The finding includes: During the entrance conference on April 23, 2008, the Qualified Mental Retardation Professional (QMRP) indicated that Client #1 had a court appointed guardian to assist him in decision making. Review of the clients record revealed that he received Ativan 2 mg prior to an audiology appointment. The record failed to have evidence that the guardian was informed of the need for the sedation prior to its administration. In an interview with the QMRP on April 25, 2008, at 10:00 AM she acknowledged that the guardian had not given consent.	W 263	W263 See responses for W124 above...5-30-08.	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by:	W 331		

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W 331	Continued From page 11 Based on observation, interview and record review, the facility's nurses failed to inform the primary care physician timely regarding changes in client conditions, and obtain physician's orders for medication prior to administering it for one of the two clients in the sample. (Client #1) The findings include: 1. Review of the facility's incident reports on April 23, 2008 at approximately 4:00 PM revealed that on July 13, 2007 Client #1 was taken to the emergency room due to an enlarged scrotum. He received a sonogram at the ER and was diagnosed with epididymitis. The client was treated and discharged. On July 19, 2007 the client was evaluated by his primary care physician (PCP) noted the following: "contusion testicles and penis, supra-pubic, what caused the trauma? Why was I not notified? where is ER sheet?" The PCP ordered that the client see the Urologist. In an interview with the Qualified Mental Retardation Professional on April 25, 2008 at approximately 9:30 AM, she indicated that although the nurse indicated that she notified the physician, it was determined that the PCP's answering service was full and she could not leave a message. 2. During evening observation on April 24, 2008 at approximately 5:45 PM, Client #1 was observed wearing adult protective undergarments. According to a Urology consultation report dated April 4, 2008, the client was prescribed the bactrim due to a positive urine culture obtained on March 20, 2008. Review of the physician's orders on April 25, 2008 at 9:40 AM failed to have evidence that the PCP ordered	W 331	W331 1. See responses for W153 2. There was a telephone order that the RN failed to transcribe onto the physician's orders in a timely manner. The Director of Nursing has met with the RN and reinforced the importance of doing so immediately...5-20-08. The order is now transcribed...5-22-08. Physician's orders will be audited monthly to insure that they accurately reflect all medications, treatments and the proper diet prescribed for each person supported at Lee...5-30-08. Further, the DON will audit compliance in her monthly meeting with each RN...6-1-08. W331 The Lead RN has been instructed to recover the missing ER report including follow up with the hospital if necessary...5-30-08. See also, the responses for W153	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 331	Continued From page 12 the medication. This information was brought to the attention of the facility's nurse during the exit conference. there was no evidence of a written or telephone order in the record. 3. Review of the incident reports on April 23, 2008, at 4:30 PM revealed an incident that occurred on May 13, 2007 that documented Client #1 fell and sustained a "small" abrasion to his right arm. The incident further indicated that first aide was provided. Review of the nursing notes on April 24, 2008 at 2:30 PM reflected a note dated June 1, 2007 that documented the client was taken to the emergency room (ER) on the previous day secondary to falling while trying to get out of his wheelchair. The nurse documented that the client had a laceration to his right elbow. On June 2, 2007, the nurse documented that the client retumed from the ER without sutures but was informed by the staff accompanying the client that he received a tetanus injection. Interviews with the Qualified Mental Retardation Professionaland Registered Nurse on April 25, 2008 at approximately 10:15 AM revealed neither QMRP or RN could locate the ER discharge record. It should be noted that the clients ER visit was not reported to the state agency as required by their policy and the District of Columbia regulations. The medical records failed to indicate that the client's primary care physician was notified of the ER visit.	W 331		
W 371	483.460(k)(4) DRUG ADMINISTRATION The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.	W 371	W371 See responses for W159 and W227	

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W 371	Continued From page 13 This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to establish an effective system to provide a training program for self-administration of medication for one of the two clients included in the sample. (Client #2) The finding includes: The facility failed to each Client #2 to administer or participate in a self medication program as recommended in his self medication assessments. During the medication administration on April 24, 2008 at 7:21 PM, Client #2 was observed receiving Atarax 25 mg, prepared and administered by the nurse. Interview with the nurse revealed that the client was not involved in a self-administration program. Observations throughout the survey revealed the the client was capable of feeding himself without assistance and following directives by staff. Review of Client #2's medical record on April 25, 2008 revealed a self medication assessment dated February 26, 2008 that indicated that the client was recommended for a program objective with nurse supervision; however, there was no evidence that the facility had implemented a self medication program.	W 371		

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I 000	INITIAL COMMENTS This re-licensure survey was conducted from April 23 through April 25, 2008. The survey was initiated using the fundamental survey process. A random sample of two residents was selected from a residential population of three males with various degrees of disabilities. The findings of this survey were based on observations at the residence and day program, staff interviews at both the group home and day program, review of clinical and administrative records to include the group home's unusual incident reports and policies.	I 000		
I 022	3501.5 ENVIRONMENTAL REQ / USE OF SPACE Each window shall be supplied with curtains, shades or blinds, which are kept clean, and in good repair. This Statute is not met as evidenced by: Based on observation, the Group Home for Mentally Retarded Person (GHMRP) failed to ensure that the blinds in the windows were in good repair. The finding includes: On April 25, 2008, beginning at 9:19 AM, an environmental walk-through of the interior and exterior of the GHMRP revealed the following: There were broken louvers in the blinds at the window in Client #1 and #2's bedrooms.	I 022	3501.5 The blinds will be replaced by...6-1-08.	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be	I 090		

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I 090	Continued From page 1 maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: 1. The floor in the half-bathroom was cracked and dirty. 2. The vent in the half bathroom was rusted. 3. The molding around the tub was black. 4. Dust was on the floor boards throughout the facility. 5. The top dresser drawer in Client #2's room was off track. 6. There was dust in the windowsill in Client #2's bedroom 7. The window sill in the kitchen had a sticky residue on it. 8. The full bathroom had a black substance build-up on the caulking (possibly mold). 9. The vent screen in the oven hood had a grease build-up on it.	I 090	3504.1 The list of repair issues cited under 3504.1 has been shared with the MTS maintenance contractor who will complete repairs for those issues relevant to his service by...6-10-08. The QMRP has reviewed the home staff relevant issues with the facility manager to insure that routine, daily upkeep and cleaning concerns are addressed in a timely manner (for example, appropriate kitchen clean up, routine dusting, routine bathroom clean up). The facility manager will use the MTS environmental checklist to audit for all repair and upkeep concerns on a routine, monthly basis and will report all repair issues to management and instruct direct care staff on responsibilities that accrue to them...6-1-08. Further, the QMRP will insure that the daily activities schedules of each person supported reflects rotating chores implemented with staff support...6-15-08.	

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I 094	3504.5 HOUSEKEEPING Adequate and appropriate storage shall be provided for each food item in accordance with § 3502.17, each piece of cleaning equipment, and each supply, utensil, linen, or other household item. This Statute is not met as evidenced by: Based on observation, the facility failed to ensure adequate storage was provided for food items. The finding includes: During the inspection of the kitchen on April 25, 2008 at approximately 9:19 AM, a bottle of lemon juice was observed in the cabinet located over the stove. Further inspection of the bottle revealed that it had been opened (no date) and instructions on the bottle indicated the contents should be refrigerated after opening. The observation was brought to the attention of the house manager.	I 094	3504.5 The RN will train the relevant staff members on proper storage of various foods and drinks...6-10-08.	
I 165	3507.4(c) POLICIES AND PROCEDURES The manual shall incorporate policies and procedures for at least the following: (c) Health and safety, which covers fire safety and evacuation, infection control, medication, and procedures for emergency and the death of a resident; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure a policy on health and safety to include trauma and death.	I 165	3507.4 (c) Attached are copies of MTS' policies addressing a client death and our End of Life policy...5-26-08.	

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I 165	Continued From page 3 The finding includes: Interview and review of the GHMRP's policies and procedures manual on April 24, 2008 revealed the GHMRP failed to have a policy to include death of a resident at the time of the survey.	I 165		
I 184	3508.5(a) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (a) All major components of the administering agency or the roles of individuals when the licensee is not an agency; This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request of management staff, the GHMRP failed to provide an organizational chart depicting titles and responsibilities. The finding includes: An organizational chart was requested at the entrance conference on April 24, 2008 at 9:00 AM. This surveyor was not provided a copy of the organizational chart .	I 184	3508.5(a) A copy of the MTS organizational charts has been faxed to HRA...5-15-08. The organizational chart is in the home policy manual. The executive Director reinforced this with the QMRP in their most recent management meeting...5-22-08.	
I 185	3508.5(b) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (b) The personnel in charge of the program components;	I 185		

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I 185	Continued From page 4 This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have an organization chart the showed the personnel in charge of the program components. The finding includes: There was no organization chart that listed the personnel in charge of the program components.	I 185		
I 186	3508.5(c) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following: (c) The categories and numbers of supportive and direct care staff; and... This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request of management staff, the GHMRP failed to provide an organizational chart depicting categories and numbers of supportive and direct care staff. The finding includes: An organizational chart was requested at the entrance conference on April 24, 2008 at 9:00 AM. This surveyor was not provided a copy or the organizational chart throughout the survey to determine the categories and numbers of supportive and direct care staff.	I 186	3508.5 (b), (c), and (d) See response for 3508.5 (a) above.	
I 187	3508.5(d) ADMINISTRATIVE SUPPORT Each GHMRP shall have an organization chart that shows the following:	I 187		

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I 187	Continued From page 5 (d) The lines of authority. This Statute is not met as evidenced by: Based on review of the policy and procedures manual and request made of management staff, the GHMRP failed to provide an organizational chart depicting the lines of authority. The finding includes: An organizational chart was requested at the entrance conference on April 24, 2008 at 9:00 AM. This surveyor was not provided a copy or the organizational chart throughout the survey to determine the lines of authority.	I 187		
I 188	3508.6 ADMINISTRATIVE SUPPORT Documentation that services have been provided as required by each resident ' s Individual Habilitation Plan including contracts, vendor agreements, receipts, and paid bills shall be available for review by authorized regulatory personnel. This Statute is not met as evidenced by: Based on interview and record review the GHMRP failed to ensure that contract for outside services are on file for the regulatory agency's review. The finding includes: Interview with the QMRP and a review of the available outside contract on April 24, 2008 failed to show evidence of any contractual agreement for the day programs in which Resident #2 attend.	I 188	3508.6 Client #2 is a new admittance. Follow up with his day program to establish an agreement with MTS will be completed by...6-1-08.	

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I 203	Continued From page 6	I 203		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to provide evidence that the supervisor discussed the contents of job descriptions with each employee at the beginning of their employment and annually thereafter. The finding includes: Review of the personnel files on April 24, 2008 failed to provide evidence that two direct care staff (Staff #3, #5 and #6) job descriptions had been reviewed.	I 203	3509.3 The updated, reviewed/signed job descriptions are attached...5-20-08. MTS has established tracking formats for all personnel file concerns and a notification process for staff to insure proactive follow up...6-10-08.	
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interviews and record review, the facility failed to achieve compliance with State regulations pertaining to health (22 DCMR Chapter 35, Section 3509.6). The finding includes:	I 206		

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I 206	Continued From page 7 The State regulatory agency conducted a review of personnel records on April 24, 2008, at which time there was no evidence that four direct care staff (Staff #2, #4, #5 and #6), psychologist, social worker and speech pathologist had a current health certificate.	I 206		
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in First Aid for employees. The findings include: On April 24, 2008, review of personnel records/training records revealed that one of the 11 direct care staff had current First Aid certificiates and four of the 11 direct care staff had current CPR cards.	I 227	3510.5 (d) See the attached copies of CRP and first aid certifications for the staff cited. MTS trains these subjects during orientation and per the expiration cycles thereafter, tracking expirations on a person-specific basis. Staff for whom certification has actually expired will receive updated training by...6-15-08.	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident's health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day.	I 379		

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I 379	Continued From page 8 This Statute is not met as evidenced by: Based on record review, the Governing Body failed to ensure its Incident Management System Policy and Procedures were followed with regards to incident reporting services of law enforcement or emergency personnel by a staff for three of the three residents in the facility. (Resident #1) The finding includes: 1. Review of the incident reports on April 23, 2008, at 4:30 PM revealed an incident that occurred on July 19, 2007 that documented Residents #1 and #3 were on a community outing here a by-stander reported that staff was observed hitting the residents in the head and pulling on their clothing. The incident was reported to the administration on July 20, 2007, however the incident was not reported to the state agency until August 4, 2007. 2. Review of the incident reports on April 23, 2008, at 4:30 PM revealed an incident that occurred on March 12, 2008 that documented Resident #2 was on discovered missing from the facility. The incident was not reported to the state agency until March 15, 2008. The issues of untimely reporting of incidents to the state agency was discussed at the exit conference on April 25, 2008 at 11:00 AM.. 3. Review of the incident reports on April 23, 2008, at 4:30 PM revealed an incident that occurred on May 13, 2007 that documented Resident #1 fell and sustained a "small" abraision	I 379	3519.10 MTS' management team which includes the President, Executive Director, QA/Special Projects Corporate Consultant, IMC/Corporate Consultant and Director of Nursing discussed this issue at length in the May 21st monthly team meeting and using this survey as evidence of the issue. Improvement in terms of timely notifications has been noted overall but some problems persist as outlined by the IMC. To insure that the IMC is immediately notified when incidents occur so that she can in turn insure timely notifications of other relevant parties including HRA, MTS' incident management procedure will be modified. The QMRP of Lee and each home will be made responsible for insuring that the IMC is notified immediately when incidents occur as opposed to delegating this responsibility to line staff as in the past. The RN will be responsible for notifying the PCP when issues involve physical health. Modifications in the existing guidelines, notification and training of the relevant staff and implementation of the new process will be completed by...6-10-08. The RN in question for issue #3 has been re trained by the Director of Health to insure that she understands that she must continue to use options to contact the PCP until reached when medical concerns must be communicated. The nurse in question admits not going beyond the initial phone call to the PCP when she found the message box to be full. Other methods for reaching the PCP have been communicated and disseminated although this is an isolated incident and not an ongoing problem...5-30-08.	

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I 379	Continued From page 9 to his right arm. The incident futher indicated that first aide was provided. Review of the nursing notes on April 24, 2008 at 2:30 PM reflected a note, dated June 1, 2007 that documented the resident was taken to the emergency room (ER) on the previous day, secondary to falling while trying to get out of his wheelchair. The nurse documented that the client had a laceration to his right elbow. On June 2, 2007, the nurse documented that the resident returned from the ER without sutures but was informed by the staff accompanying the resident that he received a tetanus injection. In an interview with the Qualified Mental Retardation Professional (QMRP) on April 25, 2008 at approximately 10:15 AM regarding the residents ER visit, she indicated that she was not aware of the ER visit. The facility's Registered Nurse was not available at that time. When asked to see the ER report, the QMRP was unable to produce it. It should be noted that the residents ER visit was not reported to the state agency.	I 379	3521.1 W159 The Executive Director has reinforced with the QMRP that she must review progress on <u>all objectives</u> formally adopted by the IDT for each person supported including self medication objectives run by nursing. The QMRP began reviewing the self medication objective...5-20-08. Although this is not a concern elsewhere, the Executive Director reminded all QMRPs of this requirement in her May meeting with the Management team...5-20-08. In addition, the Executive Director will audit program implementation and review in her monthly meetings with each QMRP. QMRP duties checklists reflect this consideration...5-30-08. W227 The self medication process that was being done informally for Client #2 has been made a formal program objective that is now being run...5-20-08. See also W159 above.	
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide habilitation and training to its residents that would enable them to acquire and maintain life skills needed to cope with their environments and achieve optimum levels of physical, mental and social functioning for one of the two reisdents in the	I 420		

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	09G074	A. BUILDING _____ B. WING _____	04/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	4012 LEE STREET, NE WASHINGTON, DC 20019

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I 420	Continued From page 10 sample. (Resident #2) The findings include: On April 24, 2008 at 7:21 PM, Resident #2 was observed being administered his medications. The Licensed Practical Nurse (LPN) prepared the resident's medications, the resident poured a cup of water and the nurse handed the resident the cup of medication and he consumed the medication with verbal prompts. Interview with the LPN indicated that the resident does not have a self medication program. Review of the self medication assessment dated February 26, 2008 on April 25, 2008 at 10:00 AM indicated that the resident would benefit from a modified version of a self medication program. Interview with the Qualified Mental Retardation Professional (QMRP) and Registered Nurse indicated that the program objective had not been developed. Review of the Individual Program Plan (IPP) dated February 27, 2008 revealed no program goal or objective for the Resident #2 to receive training in self medication adminstration.	I 420		
I 432	3521.7(c) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (c) Personal hygiene (including washing, bathing, shampooing, brushing teeth, and menstrual care); This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure residents were effectively trained in toothbrushing for one	I 432	3521.7 (c) W242 Client #2 is newly admitted to the program (March 2008). A tooth brushing objective was added to his formal program plan in May...5-20-08. In addition nursing will insure that staff is trained to support Client #2 on a daily, routine basis when he brushes including; providing touch up and/or direct brushing support if needed to insure his teeth are thoroughly brushed...6-10-08.	

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I 432	Continued From page 11 of the two residents included in the sample. (Resident #2) The finding includes: During the entrance conference with the Qualified Mental Retardation Professional (QMRP) on April 23, 2008 at approximately 3:30 PM revealed that Resident #2 was admitted into the facility on March 2, 2008. On April 23, 2008, Resident #2 was observed with brown stains on his teeth. Review of the resident's medical record revealed a dental consultation dated March 18, 2008. The findings include moderate and heavy calculus deposit on all teeth quadrants. According to the comprehensive functional assessment dated February 2008 indicated that the resident required assistance to thoroughly brush his teeth. Review of the resident's Individual Program Plan (IPP) dated February 27, 2007 on April 24, 2008 at 3:00 PM failed to identified a toothbrushing program.	I 432	3521.7 (f) W159 The Executive Director has reinforced with the QMRP that she must review progress on <u>all objectives</u> formally adopted by the IDT for each person supported including self medication objectives run by nursing. The QMRP began reviewing the self medication objective...5-20-08. Although this is not a concern elsewhere, the Executive Director reminded all QMRPs of this requirement in her May meeting with the Management team...5-20-08. In addition, the Executive Director will audit program implementation and review in her monthly meetings with each QMRP. QMRP duties checklists reflect this consideration...5-30-08.	
I 436	3521.7(f) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (f) Health care (including skills related to nutrition, use and self-administration of medication, first aid, care and use of prosthetic and orthotic devices, preventive health care, and safety); This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Mentally Retarded Persons (GHMRP) failed to ensure the	I 436	W227 The self medication process that was being done informally for Client #2 has been made a formal program objective that is now being run...5-20-08. See also W159 above.	

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I 436	Continued From page 12 habilitation and training to residents in the domain of self medication for one of the two residents in the sample. (Resident #2) The finding includes: The facility failed teach Resident #2 to administer or participate in a self medication program as recommended in his self medication assessments. During the medication administration on April 24, 2008 at 7:21 PM, Resident #2 was observed receiving Atarax 25 mg, prepared and administered by the nurse. Interview with the nurse revealed that the resident was not involved in a self-administration program. Observations throughout the survey revealed the the resident was capable of feeding himself without assistance and following directives by staff. Review of Resident #2's medical record on April 25, 2008 revealed a self medication assessment dated February 26, 2008 that indicated that the resident was recommended for a program objective with nurse supervision; however, there was no evidence that the facility had implemented a self medication program.	I 436	3521.7(g) W249 The library objective for Client #2 will be implemented by...6-15-08. Client #2 is a new admittance who came without all proper identification and as such, could not obtain a library card. The issue has been addressed at this point and his card will be obtained by...6-1-08.	
I 437	3521.7(g) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (g) Communication (including language development and usage, signing, use of the telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television,	I 437		

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I 437	Continued From page 13 telephone, and such specialized equipment as may be required); This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide habilitation and training for one of the two residents included in the sample. (Resident #2) The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and record review on April 23, 2008 revealed that Resident #2 was admitted to the facility on February 4, 2008. Further interview revealed that the resident had an Individual Habilitation Plan (IHP) meeting dated February 27, 2008. The interview with the QMRP revealed that the resident's Individual Program Plan (IPP) to visit the library and select reading material had not been implemented. The surveyor asked the QMRP about the implementation of the resident's program. The QMRP's response was that the program would be implemented soon. At the time of the survey the facility failed to ensure the program to achieve the resident's objective to visit the library had not been implemented.	I 437	3521.7(m) W126 Client #2 had his money management objective added to his program implementation plan in May...5-20-08. The QMRP had developed the objective but had not stated it pending staff training. The QMRP will insure that all objectives adopted by the IDT for each individual supported are implemented in the time frame prescribed and the Executive Director will audit compliance in her monthly meetings with each QMRP...5-30-08.	
I 443	3521.7(m) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (m) Financial management (including budgeting and banking);	I 443		

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I 443	Continued From page 14 This Statute is not met as evidenced by: Based on interview and record verification, the GHMRP failed to provide training to its residents in money management and banking for one of two residents in the sample. (Resident #2) The finding includes: Interview with the Qualified Mental Retardation Professional on April 23, 2007 at approximately 3:30 PM, revealed that Resident #2 was admitted on February 4, 2008. The QMRP further indicated that the resident had an Individual Support Plan meeting on February 27, 2008. Observations and interview with the day program staff on April 24, 2008 at approximately 10:30 AM revealed that Resident #2 participated in folding pizza boxes. The bilingual teacher at the resident's day program indicated that after the resident initial 30 day meeting, the resident could potentially earn a stipend based on his work production. Review of the Resident #2's clinical record revealed a Comprehensive Functional Assessment dated February 2007 revealed that the resident cannot identify coins or make coin combinations. Further review of the resident Individual Program Plan (IPP) dated February 27, 2008 revealed no evidence that the facility had developed a program objective based on the need from the comprehensive functional assessment.	I 443		
I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this	I 500		

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I 500	Continued From page 15 chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on observation, interview and record review, the Group Home for Persons with Mental Retardation (GHMRP) failed to observe and protect the rights of a resident, in accordance with federal regulations 42 CFR 483.420. The findings include: 1. The facility failed to establish a system that would ensure clients that were informed of their risks and benefits of their medication for one of the two clients in the sample. [See Federal Deficiency Report citation W124] 2. The facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of the client, parents (if the client is a minor) or legal guardian for one of the two clients in the sample. [See Federal Deficiency Report citation W263]	I 500	3523.1 MTS has developed standard consent forms specific to the issue of consent for sedation situations and for psychotropic drug regimens as well as one for medical procedures where informed consent is required. The QMRPs and nursing have been trained on their use and are using them for all such situations at this time. All future sedation situations will be implemented only after informed consent has been obtained from the guardian of Client #1 and the guardian or primary decision-making support person for each person supported who cannot provide informed consent themselves...5-30-08.	